

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 30, 2011

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

RE: SPA #11-52
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-52 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective May 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.
2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

(b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

(c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of enacted State statute is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, given in the New York State Register on April 27, 2011, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

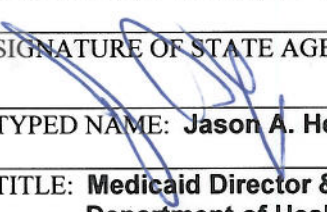
Sincerely,



Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 11-52	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE May 1, 2011	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 5/1/11 – 9/30/11 \$0 b. FFY 10/1/11 – 9/30/12 (\$30,000,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D: Page 47(aa), 47(aa)(1)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-D: Page 47(aa), 47(aa)(1)	
10. SUBJECT OF AMENDMENT: Financially Distressed Nursing Homes FMAP of 56.88% for 5/1/11-6/30/11 and 50% from 7/1/11 forward			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: June 30, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

Appendix I
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

Rate Adjustment for Financially Disadvantaged RHCFS

- (a) The Commissioner of Health shall adjust medical assistance rates of payment for services provided on and after October 1, 2004 through December 31, 2004 and annually thereafter for services provided on and after January 1, 2005 through April 30, 2011, and on and after May 1, 2012 to include a rate adjustment to assist qualifying Residential Health Care Facilities (RHCFS) pursuant to this section, provided that public RHCFS shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April 1, 2009.

Facilities that receive a rate adjustment for the period May 1, 2010 through April 30, 2011, will have their rates reduced for the rate period December 1, 2011 through December 31, 2011, by an amount equal in aggregate to the amount of the May 1, 2010 through April 30, 2011, rate adjustment.

- (b) Eligibility for such rate adjustments shall be determined on the basis of each RHCFS's operating margin over the most recent three-year period for which financial data are available from the RHCFS-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October 1, 2004 through December 31, 2004, financial information for the calendar years 2000 through 2002 shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.
- (c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based RHCFS's, for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three-year period or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this section, provided that for rate periods on and after April 1, 2009, such disqualification:
- i. shall not be applied solely on the basis of a facility's having a positive total margin in the most recent year of such three-year period;

TN #11-52 Approval Date _____

Supersedes TN #09-29 Effective Date _____

**New York
47(aa)(1)**

**Attachment 4.19-D
(6/11)**

- ii. shall be extended to those facilities in the quartile of facilities with the second smallest negative operating margins; and
 - iii. shall also be extended to those facilities with an average Medicaid utilization percentage of less than 70% during the most recent year of the three-year period.
- (d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this section, the Commissioner of Health shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three provided, that for periods on and after April 1, 2009, the amount of such average annual operating loss shall be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods. For this purpose, for hospital-based RHCFS for which the average annual operating loss cannot be calculated on the basis of submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the RHCF based on the proportion the RHCF's total revenues for the period bears to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss shall then be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods.
- (e) For periods prior to April 1, 2009, each such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this section by the applicable percentage shown in the tables below for the quartile in which the facility's negative operating margin for the three-year period is assigned.

- i. For a facility located in a county with a total population of 200,000 or more as determined by the 2000 U.S. Census:

First Quartile (lowest operating margins):	30 percent
Second Quartile	15 percent
Third Quartile	7.5 percent

- ii. For a facility located in a county with a total population of fewer than 200,000 as determined by the 2000 U.S. Census:

First Quartile (lowest operating margins):	35 percent
Second Quartile	20 percent
Third Quartile	12.5 percent

TN #11-52 **Approval Date** _____

Supersedes TN #09-29 **Effective Date** _____

Appendix II
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #11-52

This State Plan Amendment proposes to revise the State Plan to implement a payment reduction equal to the 2010 Financially Disadvantaged Payment and to eliminate the 2011 Financially Disadvantaged Payment.

Appendix III
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

Chapter 59 of the Laws of 2011

S.2809-D/A.4009-D

Part H

§ 100. Paragraph (a) of subdivision 21 of section 2808 of the public health law, as amended by section 8 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five through April thirtieth, two thousand eleven and on and after May first, two thousand twelve, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, provided, however, that public residential health care facilities shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April first, two thousand nine[-], provided further, however, that notwithstanding any contrary provision of law and subject to the availability of federal financial participation, each facility that receives a rate adjustment pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven shall have its medicaid rates reduced for the rate period December first, two thousand eleven through December thirty-first, two thousand eleven by an amount equal in aggregate to the aggregate amount of the funds such facility received pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven.

**Appendix IV
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Public Notice**

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2011, and notification of new significant changes:

All Services

- To clarify the previously noticed provision, the elimination of the trend factor has been revised to be effective on and after April 1, 2011 through March 31, 2013 and no greater than zero trend factors shall be applied. This is also revised to exclude residential health care facilities or units of such facilities that provide services primarily to children under 21 years of age, and to include hospital outpatient services. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$56) million.

- To clarify the previously noticed provision regarding the uniform two percent Medicaid payment reduction, the effective period is now April 1, 2011 through March 31, 2013. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$517.80) million.

Institutional Services

- Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all Urban Consumers less 0.25%.

The State proposes to extend, effective April 1, 2011 through March 31, 2013, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital

costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$7.85) million.

- The Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than \$51 million for the period April 1, 2011 through March 31, 2012, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the period July 1, 2011 through March 31, 2011, and as a result of decreased PPRs and PPNOs for the period April 1, 2011 through March 31, 2012. The annual decrease in gross Medicaid expenditures, not previously noticed, for state fiscal year 2011/12 is (\$4) million.

Long Term Care Services

- Continues, effective April 1, 2011 through March 31, 2013, the provision that rates of payment for RHCFS shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, the reimbursable operating cost component for RHCFS rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2011 through March 31, 2013, the long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$214) million.

- Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFS), the Commissioner of Health may grant approval of temporary adjustments to Medicaid rates to provide short term assistance to eligible facilities to accommodate additional patient services requirements resulting from the closure of other facilities in the area, including but not limited to additional staff, service reconfiguration, and enhancing information technology (IT) systems.

- Eligible facilities shall submit written proposals demonstrating the need for additional short-term resources and how such additional resources will result in improvements to the cost effectiveness of service delivery; quality of care; and other factors. Written proposals must be submitted to the department at least sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of

time and at the end of the specified timeframe, the facility will be reimbursed in accordance with otherwise applicable rate-setting methodologies. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in accordance with the facility's approved proposals and may also require that the facility submit periodic reports evaluating the progress made in achieving the benchmarks and goals. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment. The estimated increase in Medicaid expenditures for the rate increases will be offset by the decrease in Medicaid expenditures resulting from the closure of other providers.

- The 2002 rebasing methodology and the 2002 wage equalization factor methodology will be extended and will remain in effect until such time as the Statewide pricing methodology takes effect. Case mix adjustments as scheduled for July 2011 will not be made.

- The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is replaced with a Statewide pricing methodology to be effective on or after October 1, 2011 but no later than January 1, 2012.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, determined by the Commissioner of Health by regulation, and shall reflect:

- A direct statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions) and other factors to recognize other cost differentials. The direct statewide price shall also be subject to a Medicaid-only case mix adjustment.
- An indirect statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions); and
- A facility specific non-comparable component.

- Such rate components shall be periodically updated to reflect changes in operating costs.

- The non-capital component of the "specialty" rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be the rates in effect on January 1, 2009, as adjusted for inflation and rate appeals. The AIDS rates in effect January 1, 2009 shall be adjusted to reflect the elimination of the AIDS occupancy factor enacted in 2009. In addition, the trend factors attributable to 2008 and 2009 and included in such specialty rates shall be subject to the residential health care facility cap. The Commissioner may promulgate regulations, including emergency regulations, to implement the provisions of the methodology. The regulations will include provisions for rate adjustments or payment enhancements to facilitate a minimum four year transition of facilities to the methodology and may also include provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities. The regulations will be developed in consultation with the nursing home industry and advocates for residential health care facility residents. The Commissioner shall notify the Chairs of the Legislative Fiscal Committees and Health Committees in the Senate and the Assembly of such regulations. There is no increase or decrease in gross Medicaid expenditures for state fiscal year 2011/12 (including the \$210 million cap).

For the period May 1, 2011 through May 31, 2011, supplemental payments in an amount not to exceed \$221.3 million will be made to eligible residential health care facilities as determined by the Commissioner of Health, which experienced a net reduction in their pay-

ment rate for the period April 1, 2009 through March 31, 2011 as a result of the 2002 rebasing methodology, Medicaid only case mix methodology, and the application of proportional adjustments required to be made by the application of the residential health care facility (RHCF) cap. In determining the net reduction, the impact of case mix adjustments applicable to July 2010 and certain rate adjustments processed for payment after October 19, 2010 will be disregarded by the Commissioner. The following facilities, as determined by the Commissioner, are eligible for such supplemental payments.

- Facilities which were eligible for Financially Disadvantaged distributions for the 2009 period; non-government owned or operated facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds 70 percent (based on either their 2009 cost report or their most recently available cost report); and pediatric facilities or distinct units, which will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.

- Eligible facilities, other than those described in the previous paragraph above will receive supplemental payments equal to 50 percent of their net reduction. Eligible facilities which after the application of these rate adjustments that remain subject to a net reduction in their inpatient Medicaid revenue which is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years), will have their payments further adjusted so that the net reduction does not exceed two percent. Eligible facilities which have experienced a net reduction in their inpatient rates of more than \$6 million over the period April 1, 2009 through March 31, 2011, as a result of the application of proportional adjustments required to be made by the application of the RHCF cap, will have their payments further adjusted so that their net reduction is reduced to zero.

The supplemental payments previously described will not be subject to subsequent adjustment or reconciliation and will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the residential health care facility cap.

Additional rate adjustments, in the form of rate add-ons, will be made to the eligible facilities previously described for the period May 1, 2011 through May 31, 2011 in an aggregate amount equal to 25% of the payments previously described (or 25% of \$221.3 million which equals \$55.3 million). The payments will be distributed to eligible facilities in the same proportion as the total \$221.3 million of distributions made to each eligible facility.

The Commissioner may, with the approval of the Director of the Budget, and subject to the identification of sufficient nursing home related Medicaid savings to offset the expenditures authorized by this paragraph, make additional rate adjustments, in the form of rate add-ons, to the eligible facilities previously described, for the rate periods December 1, 2011 through December 31, 2012 in an aggregate amount equal to 12.5% of the payments previously described (or 12.5% of \$221.3 million which equals about \$27.7 million).

The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is \$304.30 million.

- For the rate period April 1, 2011 through June 30, 2011 the non-capital component of residential health care facility rates will be subject to a uniform percentage reduction sufficient to reduce rates by \$27.1 million. The dollar amount of this uniform reduction will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the RHCF cap. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$27.1) million.

- Facilities that receive a Financially Disadvantaged (FD) payment, for the period May 1, 2010 through April 30, 2011, shall have their Medicaid rates for the rate period December 1, 2011 through December 31, 2011 reduced by an amount equal to such FD payments. FD payments made for the annual period May 1, 2011 through April 30, 2012, shall not be made. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$60) million.

- Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by RHCFs may not include any

payment factor for return on or return of equity, or for residual reimbursement. In addition, provisions authorizing adjustments to the capital cost component of rates for proprietary facilities that would otherwise be eligible for residual reimbursement to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients are repealed. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$64) million.

Non-institutional Services

- Revision to the methodology used to establish peer groups for Federally Qualified Health Centers (FQHC's) to align the counties considered upstate and downstate with those used for the ambulatory care groups' methodology. The grouping methodology is used to determine reasonable costs for FQHC's in their respective region. The downstate region is defined as all counties comprising New York City, Nassau, Suffolk, Richmond, Westchester, Rockland, Putnam, Orange and Dutchess. All other counties are considered upstate. The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is \$4.8M.

- Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for approved services rendered on and after April 1, 2011 shall be reduced by five percent. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$13) million.

Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for home and community based rates for approved services rendered on and after April 1, 2011 shall be adjusted to reflect updated wage equalization factors and overhead adjustments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$2) million.

Effective July 1, 2011 early intervention program rates for home and community based rates for approved services rendered on and after July 1, 2011 shall be adjusted to reflect 15 minute billing increments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$3) million.

- To clarify the previously noticed provision, the uniform payment reduction will not apply to physicians, nurse practitioners, midwives and dentists in the office setting; or to free-standing clinics and free-standing ambulatory surgery centers. The \$37.5M balance of the ambulatory patient group investment will be reduced on April 1, 2011 to cover the cost of this exemption. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$12.3) million, and is included in the overall fiscal cited for the uniform across the board reduction under all services.

- Extends current provisions to services for the periods April 1, 2011 through March 31, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2011 through March 31, 2011, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$53.73) million.

- Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization

limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age or to enrollees who are developmentally disabled. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$4.94) million.

- Effective for dates of service on and after May 1, 2011, coverage of enteral formula and nutritional supplements for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease, or to address growth and development problems in children. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is (\$30.8) million.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is (\$749.12) million.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations and Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

The Department of Health is proposing to modify its two 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, as part of a major redesign of New York State's Medicaid program. Changes affecting the State's waiver programs are intended to streamline and maximize enrollment in managed care programs, simplify the program, improve quality of care and reduce costs.

Changes are effective on or after April 1, 2011, as indicated.

A. Expand Medicaid Managed Care Enrollment of Non-duals

The State is proposing to amend its federal Social Security Act Section 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, to expand enrollment in Medicaid managed care programs by requiring some of the populations previously exempt or excluded to enroll in a managed care organization (MCO). Enrollment of the new populations will be phased in over three years beginning July 2011.

Beginning 7/1/11, the following individuals will be required to enroll in a managed care plan:

- Individuals in the Recipient Restriction Program

Beginning 10/1/11, the following individuals will be required to enroll in a managed care plan:

- Individuals who have a relationship with a primary care provider not participating in any MCOs
- Individuals living with HIV (outside of New York City)
- Individuals without a choice of primary care provider within 30 miles or 30 minutes
- Non-SSI adults diagnosed as seriously and persistently mentally ill and non-SSI children diagnosed as severely emotionally disturbed
- Individuals temporarily living outside of their home district
- Pregnant women whose prenatal provider does not participate in any MCOs
- Persons receiving Mental Health Family Care
- Individuals who cannot be served by a managed care provider due to a language barrier.

Beginning 10/1/11, the following exemption from enrollment will be limited to 6 months or the completion of a course of treatment, whichever occurs first:

- Individuals with chronic medical issues under the care of a specialist provider not participating in any MCOs

Beginning 4/1/12, the following individuals will be required to enroll in a managed care plan:

- Individuals enrolled in the Long Term Home Health Care Program (LTHHCP) where capacity exists will have the option to opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program
- Individuals with characteristics and needs similar to those in the LTHHCP
- Individuals with end stage renal disease
- Individuals receiving services through the Chronic Illness Demonstration Program
- Homeless persons
- Infants under 6 months of age who were born weighing under 1200 grams or are disabled
- Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY) programs

Beginning 10/1/12

- Residents of residential health care facilities (nursing homes)

Beginning 4/1/13, the following individuals will be required to enroll in a managed care plan providing program features are in place:

- Residents of an intermediate care facility for the mentally retarded or developmentally disabled (ICF/MR or ICF/DD)
- Individuals with characteristics and needs similar to residents of an ICF/MR
- Individuals receiving services through the Nursing Home Diversion and Transition waiver
- Residents of Long Term Chemical Dependence programs
- Children enrolled in the Bridges to Health (B2H) foster care waiver program
- Non-institutionalized foster care children living in the community
- Individuals receiving services through a Medicaid Home and Community-based Services Waiver (these individuals may enroll while remaining in the waiver program)

- Individuals with characteristics and needs similar to those receiving services through a Medicaid Home and Community-based Services waiver

- Individuals receiving services through a Medicaid Model Waiver (Care at Home) Program (these individuals may enroll while remaining in the waiver program)

- Individuals with characteristics and needs similar to those receiving services through a Medicaid Model Waiver (Care at Home) Program

- Individuals eligible through the Medicaid Buy-In for the Working Disabled (those who pay a premium and those who pay no premium)

- Residents of State-operated psychiatric centers

- Blind or disabled children living separate and apart from their parents for 30 days or more

- Institutional foster care children

B. Streamline the Enrollment Process

Effective on or after 10/1/2011, the State proposes to streamline the enrollment process by standardizing the period during which all beneficiaries may select a plan. New applicants will be required to indicate their choice of plan at the time of application for Medical Assistance (MA), and if they do not choose a plan, they will be auto-assigned to a plan using the existing process. Persons already in receipt of MA will have 30 days from the day the local district or State indicates to choose a plan. If they do not choose a plan within that 30 day window, they will be auto-assigned to a plan. Pregnant women will be required to choose a plan when they apply for presumptive eligibility and will be auto-assigned after 30 days if they fail to do so.

C. Pharmacy "Carve-in" and Other Benefit Changes

Effective on or after 10/1/2011, pharmacy services will be included in the Medicaid managed care and FHPlus benefit packages. For Medicaid managed care only, personal care agency services will become the responsibility of Medicaid managed care plans effective 7/1/2011, and effective 10/1/2012, nursing facility care will be included in the benefit package.

D. Mandatory Enrollment of Medicaid Eligibles in Managed Long Term Care

Effective April 1, 2012 the State will require the transition and enrollment of people who meet the following criteria into Managed Long Term Care (MLTC) plans or other care coordination models approved by the Commissioner of Health: age 21 and older; eligible for Medicare and Medicaid; and, in need of community-based long term care services for more than 120 days. Non-dually eligible disabled adults who meet these criteria will have the option of joining a MLTC in lieu of an MMC plan. Three MLTC models now operate in New York – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. Partially capitated plans are expected to be the primary type of plan these individuals will enroll in because there is no requirement for concurrent Medicare enrollment. However, where available and when additional plan-specific enrollment criteria are met, people will have an option to select PACE or MAP as well.

Mandatory enrollment will begin in New York City and be phased-in throughout the rest of the State as plan capacity is developed. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office People with Developmental Disabilities would be exempted from mandatory enrollment in a MLTC program until the State develops appropriate program features for these populations.

Additional information concerning the Partnership Plan and the proposal can be obtained by writing to: Department of Health, Division of Managed Care, Empire State Plaza, Corning Tower, Rm. 1927, Albany, NY 12237

1115 waiver information is also available to the public on-line at www.nyhealth.gov

Written comments concerning extension of the program will be accepted at the above address for a period of thirty (30) days from the date of this notice.

PUBLIC NOTICE

Town of Oyster Bay

On April 12, 2011, by Resolution 365-2011, the Town of Oyster Bay awarded a contract to Winters MSW Holdings, LLC pursuant to section one hundred twenty-w of the general municipal law for the transfer, haul and disposal of solid wastes from the Town of Oyster Bay Solid Waste Disposal District. The validity of this contract or the procedures which led to its award may be hereafter contested only by action, suit or proceeding commenced within sixty days after the date of this notice and only upon the ground or grounds that: (1) such award or procedure was not authorized pursuant to that section, or (2) any of the provisions of that section which should be complied with at the date of this publication have not been substantially complied with, or (3) a conflict of interest can be shown in the manner in which the contract was awarded; or by action, suit or proceeding commenced on the grounds that such contract was awarded in violation of the provisions of the Constitution.

PUBLIC NOTICE

Department of State

F-2011-0008

Date of Issuance - April 27, 2011

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

In F-2011-0008, Verdant Power, LLC (Verdant) has applied to the Federal Energy Regulatory Commission (FERC), for a ten year hydrokinetic pilot license to install, operate and maintain up to 30, 5 meter diameter kinetic hydropower system 35 kW generators mounted on ten triframe mounts, as well as associated facilities, in the East Channel of the East River at Roosevelt Island, City of New York, New York County. Verdant Power, LLC proposes a phased approach and anticipates installing 3 units on 1 triframe during the third quarter of 2012, 6-9 additional units on 2-3 triframes during the third quarter of 2013 and the remaining units and triframes during the third quarter of 2014.

The stated purpose of the above mentioned proposal is "to generate up to 1 MW of emission-free electricity from the tides of the East River for delivery to New York City customers."

Verdant Power LLC's application materials are available at the Department of State's Albany office. Verdant's federal application materials are available at <http://www.ferc.gov/docs-filing/elibrary.asp> under docket # P-12611.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, May 27, 2011.

Comments should be addressed to: Division of Coastal Resources, Department of State, One Commerce Plaza, 99 Washington Ave., Suite 1010, Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE

Department of State

Notice of Review for the Town of Southold

Draft Local Waterfront Revitalization Program Amendment

A draft amendment to the Town of Southold Local Waterfront Revitalization Program (LWRP) has been prepared pursuant to provi-

sions of the New York State Waterfront Revitalization of Coastal Areas and Inland Waterways Act and the New York State Coastal Management Program (NYS CMP).

The LWRP serves as a comprehensive management program for the Town's Long Island Sound, Fishers Island Sound, Block Island Sound, Gardiners Bay and Peconic Bay waterfront resources, and was approved by the New York State Secretary of State on May 10, 2005 and incorporated into the State Coastal Management Program on November 2, 2005.

A major component of the State's CMP and the Waterfront Revitalization and Coastal Resources Act (Article 42 of the NYS Executive Law) involves designation of coastal fish and wildlife habitats which are significant due to ecosystem rarity, vulnerable species, human use, population levels, or replaceability. The CMP calls for areas so designated to be protected, preserved, and where practical, restored so as to maintain their viability as habitats.

In 2005, upon approval of the Secretary of State, the descriptions and narratives for a number of existing Significant Coastal Fish and Wildlife Habitats (SCFWH) located in Long Island Sound and Peconic Bay were revised to better reflect current conditions, and new SCFWHs were also designated. All of the changes to the Long Island Sound and Peconic Bay SCFWHs were incorporated into the New York State Coastal Management Program (CMP), as a Routine Program Implementation Action. This LWRP amendment reflects the modifications to the SCFWHs located within the Town of Southold's coastal area, such as revisions to the habitat narratives and boundaries of the Mattituck Inlet Wetlands and Beaches, and Fishers Island Beaches/ Pine Islands and Shallows SCFWHs, and the inclusion of the Goldsmith Inlet and Beach, Pipes Cove Creek and Moores Drain, and Dumpling Islands and Flat Hammock as new SCFWHs. This amendment also reflects revisions to Chapter 268 of Southold's Town Code (Waterfront Consistency Review) which will strengthen the ability of the Town to implement the LWRP by assuring that Town actions are undertaken in a manner consistent to the maximum extent practicable with the LWRP.

Upon approval by the Secretary of State, the Department of State intends to request the incorporation of the Southold LWRP amendment into the NYS CMP.

To approve this amendment to the Southold LWRP, pursuant Article 42 of the NYS Executive Law, it is required that potentially affected State, federal, and local agencies be consulted to assure that it does not conflict with existing policies and programs. For this purpose, the draft Southold LWRP amendment is available online, at <http://nyswaterfronts.com/LWRP.asp>. The draft LWRP amendment was accepted by the New York State Department of State as complete and is now available for review by potentially affected State, federal, and local agencies and the general public. Comments on the draft LWRP amendment are due by May 20, 2011.

Comments on the Draft Town of Southold LWRP amendment should be submitted by May 20, 2011 to: Kevin Millington, Department of State, Office of Coastal, Local Government and Community Sustainability, 99 Washington Ave., Suite 1010, Albany, NY 12231-0001, (518) 473-2479

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and **WHEREAS**, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and **WHEREAS**, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Ruth Noemi Colón, Acting Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED
REGISTERED LIMITED LIABILITY PARTNERSHIP REVOCATION OF REGISTRATION

A

A. JAMES DE BRUIN & SONS, LLP (95)
ALLEN JOHNSON & LONERGAN, LLP (95)
ANDREAS ESBERG & COMPANY, LLP (95)
ANDREOZZI & FICKESS, LLP (04)
ANESTHESIA ASSOCIATES OF BAY RIDGE, LLP (00)
ANTONUCCI LAW FIRM LLP (95)
ATKINSON & HEFFRON, LLP (05)
AURORA PET HOSPITAL, LLP (05)

B

B FIVE STUDIO LLP (95)
BART AND SCHWARTZ, LLP (00)
BATH AVENUE ANIMAL CLINIC, L.L.P. (00)
BECKHARD RICHLAN SZERBATY + ASSOCIATES, LLP (95)
BELDING, FRANCO, GLEASON, DRAGONE & O'BRIEN, LLP (95)

BELKIN BURDEN WENIG & GOLDMAN, LLP (95)
BENDER, CICCOTTO & CO., C.P.A.'S, L.L.P. (95)
BENTEL & BENTEL, ARCHITECTS/PLANNERS, LLP (95)
BERWITZ & DITATA LLP (00)
BLATT & DAUMAN LLP (04)
BLOOM & CO., LLP (00)
BRAND BRAND NOMBERG & ROSENBAUM, LLP (04)
BRATSAFOLIS & FEINERMAN, LLP (05)
BRONSTEIN, VAN VEEN & SCHUCK, LLP (05)
BUFFALO EMERGENCY ASSOCIATES, L.L.P. (00)
BURKE, ALBRIGHT, HARTER, & REDDY, LLP (95)

C

CAMERON ERSKINE LLP (05)
CAMPBELL & SHELTON LLP (04)
CARABBA, LOCKE LLP (99)
CARLOS M. VELAZQUEZ & ASSOCIATES, LLP (05)
CASPER & FISCHER, LLP (05)
CASTLE HILL MEDICAL CARE LLP (05)
CASTRO & KARTEN LLP (00)
CATSKILL NEUROSCIENCES & RADIOLOGY ASSOCIATES, LLP (00)

CHEHEBAR & DEVENEY LLP (05)
CHRISTOPHER CHIROPRACTIC CENTER, L.L.P. (00)
CLARK, CUYLER, MAFFEI & MEDEROS, LLP (05)
COFFINAS & COFFINAS, LLP (00)
COLAMARINO & SOHNS, LLP (95)
COLEMAN, RHINE & GOODWIN LLP (95)
CONDOR ROCK CONSULTING, LLP (04)
COSTAS KONDYLIS AND PARTNERS LLP (00)
CRONIN & VRIS, LLP (00)
CUSACK & STILES LLP (95)

D

D&K CHIROPRACTIC OF NEW YORK, LLP (05)
DECKER, DECKER, DITO & INTERNICOLA, LLP (05)
DEERPARK ANESTHESIA GROUP, LLP (05)
DELANNEY & ASSOCIATES, LLP (05)

DELANNEY & ASSOCIATES, LLP (05)
DELAWARE PEDIATRIC ASSOCIATES, LLP (05)
DEMASCO, SENA & JAHELKA LLP (00)
DENTAL ARTS OF GLEN COVE, LLP (05)
DENTO FACIAL ASSOCIATES OF NEW YORK, LLP (95)
DEVINE & MCCORMICK LLP (00)
DICKERSON TOMASELLI & MULLEN LLP (05)
DRAGA EYE CARE & SURGERY ASSOCIATES, LLP (95)
DURBEN & TOSTI, LLP (95)

E

E, R AND O TELE COMMUNICATIONS, LLP (05)
EARYES ALU, LLP (05)
EE&K RESIDENTIAL ARCHITECTURE, RLLP (05)
EISENBERG & MARGOLIS, LLP (05)
EISENBERG & SCHNELL, LLP (00)
ELEFANTE & PERSANIS, LLP (00)
ELHILOW & MAIOCCHI, LLP (95)
ELMWOOD PEDIATRIC GROUP, LLP (95)
ENGEL, MCCARNEY & KENNEY LLP (05)

F

FARBER, P.T., L.L.P. (05)
FERGUSON & JOSEPH, LLP (05)
FISCHETTI & PESCE, LLP (00)
FLANAGAN, COOKE & FRENCH, LLP (00)
FLEISCHMAN & BEKERMAN, LLP (05)
FORENSIC PSYCHOLOGY ASSOCIATES, LLP (05)
FRANK & ZIMMERMAN & COMPANY, LLP (95)
FRIEDMAN, HIRSCHEN & MILLER LLP (05)
FULVIO & ASSOCIATES, L.L.P. (95)

G

G.R. REID ASSOCIATES, LLP (05)
GABER, BERARD & DONAHUE LLP (00)
GALLO & DARMANIAN, LLP (05)
GARGUILO & ORZECZOWSKI LLP (99)
GAUTHIER & MARTIAN LLP (00)
GENSER, DUBOW, GENSER & CONA LLP (99)
GIAIMO ASSOCIATES, L.L.P. (05)
GIOVANNIELLO & UDELL CPAS LLP (95)
GOLDSTEIN, BULAN & CHIARI, LLP (95)
GORDON, HUIE & FEIGENBAUM LLP (95)
GOSHOW ARCHITECTS, L.L.P. (00)
GOSMAN & DIAMOND, LLP (00)
GREENFIELD IMAGING ASSOCIATES WEST LLP (00)
GROUPS FOR GROWTH, LLP (95)
GULLACE & WELD LLP (00)

H

H. BRADLEY DAVIDSON, D.D.S. AND MICHAEL K. KEATING, D.D.S., (95)
HALKET WEITZ, LLP (05)
HALL DICKLER LLP (95)
HAMILTON ANESTHESIA ASSOCIATES, LLP (95)
HANDSMAN & KAMINSKY LLP (95)
HEARD & O'TOOLE LLP (00)
HEART RHYTHM CONSULTANTS OF NEW YORK LLP (05)
HIA-BENSONHURST IMAGING ASSOCIATES LLP (95)
HINCKLEY & HEISENBERG LLP (00)
HIRSCH, LEVINE, GREENE, INDRIOLO & HISIGER, L.L.P. (99)
HOFFMAN & ROTH, LLP (95)
HOLLYER BRADY BARRETT & HINES LLP (95)

HUDSON VALLEY BONE AND JOINT SURGEONS LLP (95)

I

IRIS SCHOENBERGER OTR LLP (05)
ISLAND HEIGHTS PEDIATRICS, LLP (95)

J

JACKSON & JACKSON LLP (05)
JACKSON & NASH, LLP (95)
JFM DENTAL, L.L.P. (95)
JOSEPH & TERRACCIANO, LLP (05)
JOSEPH M. SIMANTOV & ASSOCIATES, LLP (05)
JOSEPH, RENNIE & ASSOCIATES, LLP (05)

K

KANTER & KANTER LLP (05)
KAPLAN FOX & KILSHEIMER LLP (95)
KAPLOWITZ DAVIS, L.L.P. (05)
KAPLOWITZ FIRM, LLP (05)
KARASYK AND MOSCHELLA, LLP (04)
KAUFMANN & KAUFMANN PH.D'S., LLP (00)
KELLY MASSAD LLP (95)
KIERNAN, ANGIULO & HOROWITZ, LLP (00)
KILLIAN, LEGAKIS & VETERE LLP (99)
KUCZINSKI, VILA & ASSOCIATES, LLP (05)
KUHARSKI & LEVITZ, L.L.P. (00)

L

LAW OFFICE OF MURACA & KELLY, L.L.P. (95)
LAW OFFICES OF BROGDON & BUNCH, LLP (04)
LAW OFFICES OF CLIFFORD S. NELSON, LLP (00)
LAW OFFICES OF THOMAS L. COSTA, LLP (95)
LAWLER, MATUSKY & SKELLY ENGINEERS LLP (95)
LAZAR SANDERS THALER & ASSOCIATES, LLP (05)
LAZAR SANDERS, LLP (95)
LEFKOWITZ, LOUIS, SULLIVAN & HOGAN, L.L.P. (00)
LEHR CONSULTANTS INTERNATIONAL LLP (05)
LENSON LAW GROUP, LLP (04)
LEVINE SAMUEL, LLP (95)
LEVITT & VOGEL LLP (95)
LIFE CARE NEPHROLOGY GROUP, LLP (95)
LOCKE PARTNERSHIP, LLP (00)
LONG ISLAND NEUROSCIENCE SPECIALISTS, L.L.P. (04)
LONG POND PEDIATRICS, LLP (00)
LOUGEN, VALENTI, BOOKBINDER & WEINTRAUB, LLP (00)
LUTHRA AND GUPTA, M.D., LLP (04)

M

MALCOLM S. TAUB LLP (00)
MANHASSET ALLERGY & ASTHMA ASSOC., LLP (95)
MARCOS & NEGRON, L.L.P. (95)
MARCUS, OLLMAN & KOMMER LLP (05)
MAYER & COMPANY LLP (04)
MCCORMICK & O'BRIEN LLP (05)
MCCULLOUGH GOLDBERGER & STAUDT, LLP (00)
MCGREEVY & HENLE, LLP (05)
MEDINA & KETOVER, LLP (05)
MENTZER & HIGGINS, LLP (99)
MICHAEL F. WEISS, M.D. AND SHERYL S. COHEN, M.D., LLP (00)
MICHAEL TARTELL, M.D. AND SPYROS A. HARISIADIS, M.D., LLP (95)
MISTUR RIEBE ARCHITECTS LLP (05)
MITOFSKY SHAPIRO NEVILLE & HAZEN, LLP (00)

MORDOWITZ & LEMBERG LLP (00)
MOREA SCHWARTZ LLP (05)
MORRIS DUFFY ALONSO & FALEY, LLP (95)
MULRY & SHAUB, LLP (00)
MUSCATO & BOGULSKI, LLP (05)

N

NANGIA & KAZANSKY L.L.P. (00)
NASSAU NEPHROLOGY LLP (99)
NELSON & POPE, LLP (95)
NEW YORK GROUP FOR PLASTIC SURGERY, LLP (95)
NEW YORK MEDICAL MASSAGE PRACTICE L.L.P. (99)
NIMKOFF ROSENFELD & SCHECHTER, LLP (95)
NORTHERN WESTCHESTER SURGICAL ASSOCIATES, LLP (05)

O

O'NEILL & THATCHER, LLP (95)
O'SHEA PARTNERS LLP (05)

P

PADELL NADELL FINE WEINBERGER LLP (00)
PALL AND PALL, LLP (05)
PAYKIN MAHON ROONEY & KRIEG LLP (95)
PEDIATRIC ASSOCIATES OF BATAVIA, LLP (04)
PEIX & MARCHETTI, ARCHITECTS, L.L.P. (95)
PELAGALLI, WEINER, RENCH & THOMPSON, LLP (95)
PENN & VAN METER ARCHITECTS, LLP (95)
PERRY & CAMPANELLI, LLP (00)
PITCHFORD SEMERDJIAN LLP (05)
POLON & GLICKSMAN, L.L.P. (00)
POTTISH FREYBERG MARCUS & VELAZQUEZ, LLP (95)
POWERS SHAPIRO STEIN LLP (05)
PROKIDS, LLP (95)

R

R & J MANAGEMENT, LLP (05)
REDNISS MOODY LLP (05)
REINACH WOLF, ROTHMAN & STERN, LLP (05)
RICHMOND RADIOLOGY ASSOCIATES, LLP (00)
ROBINSON BREIT & CO, LLP (05)
ROBSON & MILLER LLP (95)
RODGERS & COPPOLA LLP (95)
RODMAN & RODMAN, LLP (95)
ROGOVIN GOLUB BERNSTEIN & WEXLER, L.L.P. (95)
ROMEO & SCHMITT, LLP (05)
ROSENBERG FELDMAN SMITH LLP (05)
ROTHFELD & POHL, LLP (95)
ROUZARD & ROUZARD, LLP (05)
RUFOLLO & BARBERESI LLP (05)
RUSSO, KEANE & TONER, LLP (00)
RYAN & STANTON LLP (00)

S

SAGA SPORTS MEDICINE CENTER LLP (99)
SALE & GROOTHUIS, LLP (00)
SAMSON FINK & DUBOW LLP (95)
SASSON BLAIVAS LLP (05)
SCARCELLA AND LA TORRE, LLP (04)
SCHIFFERLI & MARTIN, LLP (05)
SCHNEIDER & LEVINE LLP (00)
SCHNEIDER & PFAHL, LLP (99)
SCHRADER & ISRAELY, LLP (04)
SCHUYLER EMERGENCY PHYSICIANS ASSOCIATES, RLLP (05)

SEIDEL & GIANTURCO, LLP (00)
 SESSLER & CHILEWICH, L.L.P. (99)
 SHANDELL, BLITZ, BLITZ & ASHLEY, LLP (95)
 SHAW, PERELSON, MAY & LAMBERT, LLP (95)
 SHELDON ZUCKERMAN, M.D. AND ALBERT J. FERRARA,
 D.O., L.L.P. (05)
 SHERESKY ARONSON MAYEFESKY & SLOAN, LLP (95)
 SHOLES & MILLER, LLP (00)
 SIEGEL, SOMMERS & SCHWARTZ, LLP (95)
 SIFRE, INIGUEZ & VITARELLI, LLP (05)
 SILBERBERG & SCHERER, LLP (95)
 SIMMONS, JANNACE & STAGG, L.L.P. (95)
 SIX CENTURY HILL PARTNERSHIP, L.L.P. (99)
 SMITH & NEWMAN, LLP (05)
 SMOLIN & ALTAMURA LLP (05)
 SOFER & HAROUN, L.L.P. (95)
 SOTO, SANCHEZ & NEGRON, LLP (04)
 SPACE SMITH LLP (05)
 SPORTS MEDICINE ARTHROSCOPIC RECONSTRUCTIVE
 JOINT AND TRAUMA (95)
 SPRITZER, KAUFMAN & COMPANY LLP (05)
 SRA & ASSOCIATES LLP (95)
 STEIN RISO MANTEL, LLP (95)
 STEPHEN H. GREEN M.D., F.A.C.S. & STANLEY K. KLAUS-
 NER M.D., (95)
 STULMAKER, KOHN & RICHARDSON, LLP (95)
 SUFFOLK CHEST PHYSICIANS, L.L.P. (95)
 SYLVOR & RICHMAN, LLP (95)
 T
 TABAT, COHEN & BLUM, LLP (00)
 TAYLOR & MRSICH, LLP (05)
 TEPEDINO & COMPANY LLP (95)
 THE HERMES GROUP LLP (95)
 THE LAW FIRM OF CARL STEIN & ASSOCIATES, LLP (05)
 THE LAW OFFICE OF JANE B. PULLEN, L.L.P. (05)
 THE LAW OFFICES OF KRAUSE & MAUSER, LLP (05)
 THE MAURO LAW FIRM, LLP (05)
 THE MCDONOUGH LAW FIRM, L.L.P. (95)
 THEOBALD AND ATANASIO, LLP (05)
 THOMAS & GRAHAM, LLP (95)
 THREE BY THE SEA ASSOCIATES, LLP (05)
 TILEM & CAMPBELL, LLP (04)
 TOOLS FOR LANGUAGE & COMMUNICATION LLP (05)
 TOWNSEND & VALENTE, LLP (95)
 TRATNER, MOLLOY & GOODSTEIN LLP (05)
 TREUHAFT & ZAKARIN, LLP (05)
 U
 UNCYK, BORENKIND & NADLER, LLP (95)
 UNIVERSITY PAIN CENTER, LLP (95)
 UPPER MAIN STREET & MCCHESENEY, LLP (00)
 USA PAIN, LLP (05)
 V
 VOLGENAU & BOSSE, LLP (00)
 W
 WALL STREET FOOT GROUP, L.L.P. (05)
 WALLACH & ELEFANT, LLP (00)
 WATKINS & WATKINS, L.L.P. (05)
 WEISS & RANALDO, L.L.P. (05)
 WELBY, BRADY & GREENBLATT, LLP (95)
 WELT, GABRIELS, SCHUNK & DALY, LLP (95)

WESTERN NEW YORK PEDIATRIC ASSOCIATES LLP (95)
 WHITE, FLEISCHNER & FINO LLP (00)
 WHITTEMORE DOWEN LLP (95)
 WOLMAN, BABITT & KING, L.L.P. (95)
 X
 XYLAS & ZICCARDI, LLP (95)
 Y
 YOUR FAVORITE CONSTRUCTION LLP (05)
 Z
 ZWANGER-PESIRI-LIDI, LLP (05)
 FOREIGN REGISTERED LIMITED
 NY REGISTERED FOREIGN LIMITED LIABILITY PARTNER-
 SHIP REVOCATION OF REGISTRATION
 A
 A.M. PEISCH & COMPANY, LLP (05) (VT)
 B
 BARITZ & COLMAN LLP (05) (FL)
 C
 CAPITAL LAW GROUP, LLP (05) (DC)
 D
 DPK&A ARCHITECTS, LLP (00) (PA)
 H
 H2L2 ARCHITECTS/PLANNERS LLP (00) (PA)
 L
 LINEBARGER GOGGAN BLAIR & SAMPSON, LLP (05) (TX)
 M
 MATSON, DRISCOLL & DAMICO, LLP (00) (GA)
 N
 NOERR LLP (05) (GE)
 O
 OLENDERFELDMAN, LLP (05) (NJ)
 R
 RAICE, PAYKIN, GREENBLATT, LESSER & KRIEG, LLP (05)
 (NJ)

[SEAL]

WITNESS my hand and the official seal
 of the Department of State at its office in
 the City of Albany this twenty-seventh
 day of April in the year two thousand
 eleven.

RUTH NOEMÍ COLÓN
Acting Secretary of State

PUBLIC NOTICE

Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Steven Rocklin, Codes Division, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2011-0108 Matter of Mario Vigliotta, Jabez Expiditing, 648 Horseblock Road, Farmingville, NY 11738, for a variance concerning life-safety requirements with ceiling heights in conjunction with alterations to a basement in a single-family dwelling.

Involved is a one-family dwelling, approximately 3,000 square feet in area, two stories in height of type VB construction, located at 93 Aspen Road, Mastic Beach, Town of Brookhaven, Suffolk County, New York.

2011-0113 Matter of Calamar- Jolelyn BOS, c/o Richard A. Molnar, VP, 3949 Forest Pkwy. for a variance concerning requirements for number of and handicap accessible toilets.

Involved is the construction of a two-story building of wood frame construction for permanent multiple dwelling occupancy, located at 100 Weiss Ave., Town of Orchard Park, County of Erie, State of New York.

2011-0118 Matter of William F. Cronin Jr., 116 Rosemary Lane, Centereach, NY 11720, for a variance concerning fire-safety requirements for door width to a dwelling unit, dwelling unit separation and minimum height under beams in conjunction with alterations to a basement in a single-family dwelling.

Involved is a single-family dwelling, of approximately 2,314 square feet in area, two stories in height of type VB construction, located at, 116 Rosemary Lane, Centereach, Town of Brookhaven, Suffolk County, New York.

2011-0126 Matter of Roger P. Smith, A.I.A., BBS Architecture and Engineering, 244 East Main Street, Patchogue, NY 11772, for a variance concerning fire-safety requirements for minimum design flood elevation heights in conjunction with the construction of a new Ferry Terminal.

Involved is a proposed Ferry Terminal, of a mixed B/S-2/A-3 (Business/Storage/Assembly) occupancy, approximately 5,825 square feet in area, one story in height of type VB construction, located at, Bayberry Walk, Village of Ocean Beach, Suffolk County, New York.

2011-0128 Matter of Bruce Dumbauld for Bergmann Associates, 200 First Federal Plaza, 28 East Main Street, Rochester, NY 14614, for a variance concerning Uniform Code requirements including relief from a required smoke control system. The subject building is classified as a B (business occupancy) college building three stories in height, of Type IIB (unprotected non-combustible) construction, and approximately 1000,000 square feet in gross area. The building is located at SUNY Oswego, Wilber Hall and Park Hall, in the City of Oswego, Oswego County, State of New York.

2011-0129 Matter of James P. Brasley, Architect, 10 Cambridge Court, Fairport, NY 14450, for a variance concerning Uniform Code requirements including relief from maintaining a required sprinkler system. The subject building is classified as an S1 (Moderate hazard storage occupancy) warehouse, three stories in height, of Type III (unprotected Ordinary) construction, and is approximately 161,091 square feet in gross area. The building is located at 243 Gorham Street, in the City of Canandaigua, Ontario County, State of New York.

2011-0130 Matter of David and Betty Thompson, 808 3rd Avenue, 106, Bradenton, FL 34205, for a variance concerning Uniform Code requirements including relief from sprinkler requirements. The subject building is classified as an R2 (Permanent occupancy residential) apartment building, four stories in height, of mixed Type Vb (unprotected wood frame) construction. The building is located at 409 South Main Street, in the City of Geneva, Ontario County, State of New York.

2011-0134 Matter of Adam Richter for T.Y. Lin International Engineering, Architecture & Land Surveying, PC, 255 East Avenue, Rochester, NY 14604, for an appeal of the code enforcement official's determination regarding distance of travel and the common path of egress travel. There are eight subject buildings which are classified as R-2 (residential permanent occupancy) townhouse buildings, three stories in height, of Type 5B (unprotected wood frame) construction, approximately 14,548 square feet in gross area. The buildings are located at Erie Harbor, 205-375 Mount Hope Avenue, in the City of Rochester, Monroe County, State of New York.

Sealed bids for 2,506 tons more or less red pine, 1.6 MBF more or less white ash, 0.2 MBF more or less black cherry, 0.1 MBF more or less hard maple, 6 cords more or less misc. hardwood, located on Madison Reforestation Area No. 1, Stand(s) E-33, 51, 56, 60, 61 and 64, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY, 12233-5027 until 11:00 a.m., Thursday, May 5, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

**SALE OF
FOREST PRODUCTS
Madison Reforestation Area No. 1
Contract No. X008189**

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Appendix V
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

**LONG-TERM CARE FACILITY
SERVICES
State Plan Amendment #11-52**

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-(A or D) of your state plan.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-

07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If**

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: The payments authorized for this provision are not supplemental or enhanced payments.

- 4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2011.

- 5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: The rate methodology included in the approved state plan for nursing facility services is a cost based prospective payment methodology subject to ceiling. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

Assurances:

- 1. In compliance with provisions of the Recovery Act, the State should provide assurances that they are in compliance with the terms of the Recovery Act concerning (1) Maintenance of Effort (MOE); (2) State or local match; (3) Prompt payment; (4) Rainy day funds; and (5) Eligible expenditures (e.g. no DSH or other enhanced match payments).**

Response: The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment, rainy day funds, and eligible expenditures. In addition,

the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

2. **The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.**

Response: In New York State, Indian Health Programs and Urban Indian Organizations do not furnish long-term care services; therefore, solicitation of advice on this issue was not applicable.

Appendix VI
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Access Questions

**LONG TERM CARE SERVICES
State Plan Amendment #11-52**

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

- 1. Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

Response: This amendment will implement a payment reduction equal to the 2010 Financially Disadvantaged Payment and will eliminate the 2011 Financially Disadvantaged Payment. The \$60 million in financially disadvantaged payments/resources were reallocated to help fund (in a budget neutral manner) the supplemental rebasing payments to homes defined as financially disadvantaged and described in SPA 11-41.

- 2. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) or Office of Long Term Care (OLTC), as appropriate, in order to discontinue services. These Offices monitor and consider such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

- 3. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: This change was enacted by the State Legislature as part of the negotiation of the 2011-12 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented in 2010-11, the initiative will invest over \$600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award \$600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.